NATUROPATHIC INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____ Date: _____ _____

Address: _____City:_____ Prov:_____ Postal:_____

Email: _____ Occupation: _____

Telephone Home: _____ Work: _____ Mobile:_____

Emergency contact: _____ Phone: _____ Relation: _____

Do you have health insurance with naturopathic medical coverage? ❑ Y ❑ N

How did you hear about this clinic: _____

Other health care providers:

1. Name: _____ 2. Name: _____ 3. Name: _____

Profession:_____ Profession: _____ Profession: _____

Phone:_____ Phone: _____ Phone: _____

Fax: _____ Fax: _____ Fax: _____

CONTEXT OF CARE

Successful health care is only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Your time and thoughtfulness in completing this intake form will aid with the assessment of your health needs.

Why did you choose decide to seek naturopathic care?

_____

What do you know about our approach to wellness?

_____

What three (3) expectations do you have from this visit?

1. _____
2. _____
3. _____

What ***long term*** expectations do you have of your naturopathic doctor?

_____

What is your present level of commitment to making the necessary lifestyle changes to addressing your current health condition? *(Rate from 0 to 10, with 10 being 100% committed)*

0 1 2 3 4 5 6 7 8 9 10

What behaviours/habits do you engage in regularly that **supports** your health? (Please list)

_____

_____

What are the **potential challenges** that might prevent you from achieving your health goals?

_____

_____

Current Marital Status: _____ Name of partner: _____ Number of dependents: ____

Who is/are your biggest support(s)?

_____

What do you LOVE to do?

_____

_____

HEALTH INFORMATION

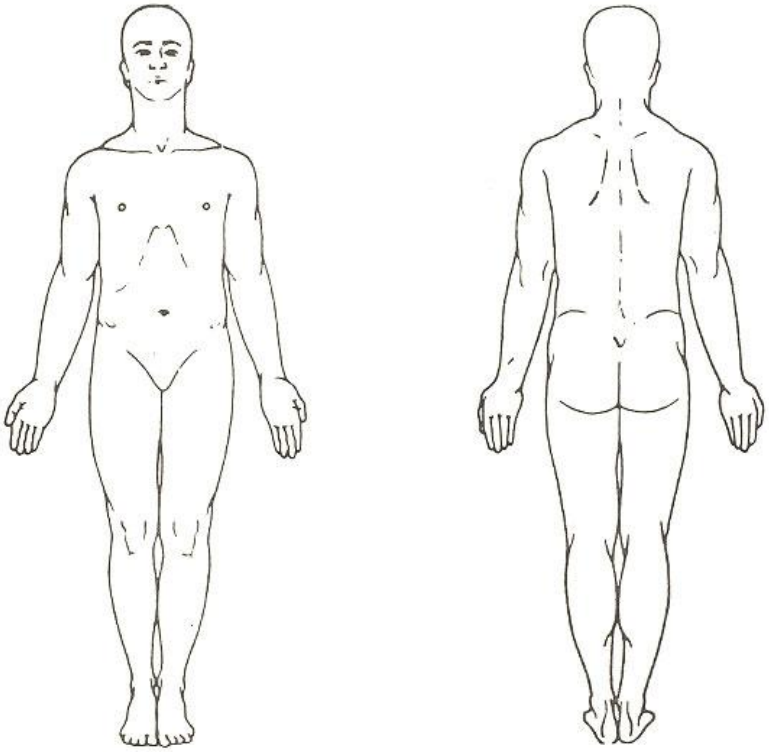
Please list your health concerns in order of importance and the date or age of onset:

1. _____ Date/Age: _____
2. _____ Date/Age: _____
3. _____ _____ Date/Age: _____
4. _____ Date/Age: _____

Please list your most stressful life experiences (physical or psychological):

1. _____ Date/Age: _____
2. _____ Date/Age: _____
3. _____ Date/Age: _____

Please mark, on the drawings below, the areas where you feel discomfort. Put **E** if external, or **I** if internal, near the areas, which you mark. Put **EI** if both external and internal.



MEDICAL HISTORY

Personal and Family History

For each condition that applies to you and/or family members, please circle who the applies to: "Self" if it relates to you and/or father (F), mother (M), sibling (S), Grandparent (G), your child (C). Please circle "Past" if the condition is resolved, or "Current" if it is ongoing and current.

Condition	Relation (please circle)	Your status (please circle)	Condition	Relation (please circle)	Your status (please circle)
Alcoholism/ addiction	Self F M S G C	Past/Current	High blood pressure	Self F M S G C	Past/Current
Allergies	Self F M S G C	Past/Current	Low blood pressure	Self F M S G C	Past/Current
Heart disease	Self F M S G C		High cholesterol	Self F M S G C	Past/Current
Anemia	Self F M S G C	Past/Current	Hepatitis	Self F M S G C	Past/Current
Arthritis	Self F M S G C	Past/Current	Headaches	Self F M S G C	Past/Current
Asthma	Self F M S G C	Past/Current	Kidney disease	Self F M S G C	Past/Current
Bladder/urinary disease	Self F M S G C	Past/Current	Skin problems	Self F M S G C	Past/Current
Cancer	Self F M S G C	Past/Current	Stroke	Self F M S G C	Past/Current
Diabetes	Self F M S G C	Past/Current	Tuberculosis	Self F M S G C	Past/Current
Depression/ other mental illness	Self F M S G C	Past/Current	Thyroid disease	Self F M S G C	Past/Current
Eczema	Self F M S G C	Past/Current	Osteoporosis	Self F M S G C	Past/Current
Epilepsy	Self F M S G C	Past/Current		Self F M S G C	Past/Current
Lung disease	Self F M S G C	Past/Current		Self F M S G C	Past/Current

Please list any **past surgeries or hospitalizations** with the approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Please list all **past injuries** (ie. Broken bones, joint sprains, burns, falls, car accidents etc.) with the approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

SUPPLEMENTS/DRUG MEDICATIONS

Please list all **current** vitamins/minerals, herbs, or homeopathic remedies, along with the daily dose, how long you have taken it and the reason for the supplement.

Supplement	Dose/day	How long?	Reason for Supplement
1.			
2.			
3.			
4.			
5.			
6.			

Please list all **current** medications (prescription and over-the-counter), the daily dose, how long you have taken it, and the reason for the prescription.

Medication	Dose/day	How long?	Reason for Medication
1.			
2.			
3.			
4.			
5.			
6.			

Please list any adverse reactions or side effects that you have experienced and which supplement/medication you suspect to be the cause:

_____

_____

In the last 10 years, approximately how many times have you been prescribed antibiotics have you taken? _____

LIFESTYLE

Please answer the following as it **applies today.**

	Quantity/day
Drink wine ❑Y ❑N	
Drink beer ❑Y ❑N	
Do you smoke ❑Y ❑N	
Recreational drug use ❑Y ❑N	
Dietary restrictions ❑Y ❑N	Vegan❑ Vegetarian❑ Other_____

Please list all allergies (food, medication, environmental): _____

_____

Please describe the emotional climate of your home: _____

_____

_____

Rate your stress level (10 = high)

1 2 3 4 5 6 7 8 9 10

In your everyday life, your present faith/spiritual practices are (10 = very important):

1 2 3 4 5 6 7 8 9 10

Please provide any additional comments, questions or concerns you have regarding your health or naturopathic care:

_____

_____

_____

_____

_____

_____

Thank you for taking your time to complete this intake form, all information gathered here will contribute to the success of your naturopathic care.